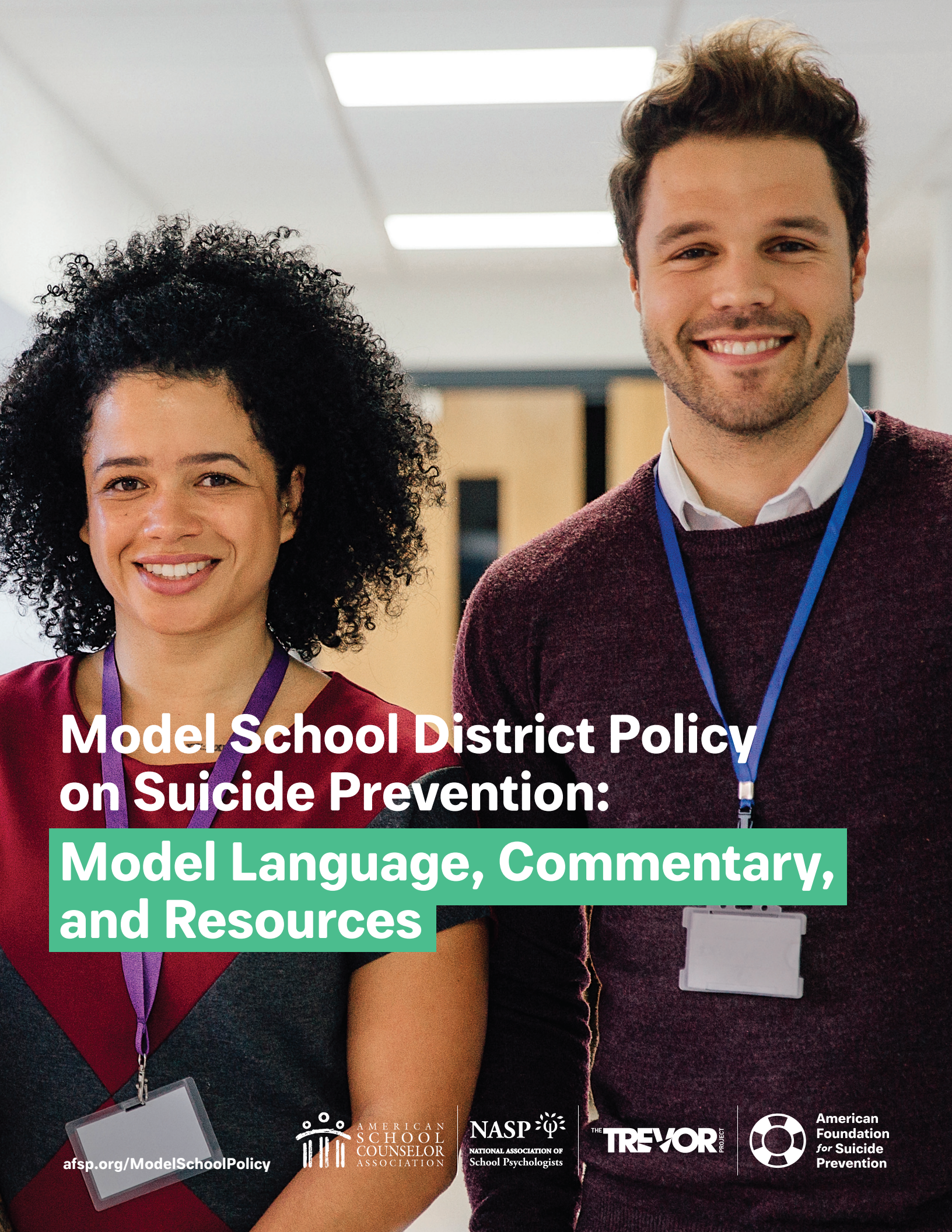

Model School District Policy on Suicide Prevention:

Model Language, Commentary, and Resources

afsp.org/ModelSchoolPolicy

AMERICAN SCHOOL COUNSELOR ASSOCIATION

NASP NATIONAL ASSOCIATION OF School Psychologists

THE TREVOR PROJECT

American Foundation *for* Suicide Prevention

Contributing Individuals

Authors of the Second Edition

Christine Moutier, M.D.
Chief Medical Officer, AFSP

Doreen S. Marshall, Ph.D.
Vice President of Programs, AFSP

Jill Cook, M.Ed., CAE
Assistant Director, ASCA

Kelly Vaillancourt Strobach, PhD, NCSP
Director of Policy and Advocacy, NASP

Sam Brinton
Head of Advocacy and Government Affairs, The Trevor Project

Reviewers of the Second Edition

Amy R. Cannava, Ed.S., NCSP
School Psychologist, Montgomery County Public Schools, Rockville, MD

Nicole Gibson, MSW
Director of State Policy & Grassroots Advocacy, AFSP

Madelyn Gould, Ph.D., MPH
Professor of Epidemiology (in Psychiatry), Columbia University Medical Center, New York, NY

Jill Harkavy-Friedman, Ph.D.
Vice President of Research, AFSP

Richard Lieberman, M.A., NCSP
Lecturer, Graduate School of Education, Loyola Marymount University, Los Angeles, CA

Amy Loudermilk, MSW
Manager of Grantee & State Initiatives, Suicide Prevention Resource Center

David N. Miller, Ph.D.
Associate Professor of School Psychology, Department of Educational & Counseling Psychology, University at Albany, State University of New York, Albany, NY

Keygan Miller, M.A Ed & HD, M.Ed.
Associate for Advocacy and Government Affairs, The Trevor Project

David Nash, Esq.
Director of LEGAL ONE, Foundation for Educational Administration

Scott Poland, Ed.D.
Professor, College of Psychology, and Co-Director, Suicide and Violence Prevention Office, Nova Southeastern University, Fort Lauderdale, FL

Jonathan B. Singer, Ph.D., LCSW
Associate Professor, Loyola University School of Social Work, Chicago, IL; Founder and Host, Social Work Podcast

Carolyn Stone, Ed.D.
Professor, Counselor Edcuation, College of Education & Human Services, University of North Florida, Jacksonville, FL

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Contributing Groups

American Foundation for Suicide Prevention (AFSP)

Is dedicated to saving lives and bringing hope to those affected by suicide. AFSP is creating a culture that's smart about mental health through education and community programs, developing and enhancing suicide prevention efforts through research and advocacy, and providing support for those affected by suicide. Led by CEO Robert Gebbia and headquartered in New York, with a public policy office in Washington, D.C., AFSP has local chapters in all 50 states with programs and events nationwide. Learn more about AFSP in its latest **Annual Report**, and join the conversation on suicide prevention by following AFSP on **Facebook**, **Twitter**, **Instagram**, and **YouTube**. Learn more at **afsp.org**.

American School Counselor Association (ASCA)

Is a nonprofit, 501(c)(3) professional organization based in Alexandria, Va. ASCA promotes student success by expanding the image and influence of school counseling through leadership, advocacy, collaboration and systemic change. ASCA helps school counselors guide their students toward academic achievement, career planning and social/emotional development to help today's students become tomorrow's productive, contributing members of society. Founded in 1952, ASCA has a network of 50 state and territory associations and a membership of approximately 36,000 school counseling professionals. For additional information on the American School Counselor Association, visit **www.schoolcounselor.org**.

National Association of School Psychologists (NASP)

Represents more than 25,000 school psychologists who work with students, educators, and families to support the academic achievement, positive behavior, and mental wellness of all students. NASP promotes best practices and policies that allow school psychologists to work with parents and educators to help shape individual and system wide supports that provide the necessary prevention and intervention services to ensure that students have access to the mental health, social/emotional, behavioral, and academic supports they need to be successful at home, at school, and throughout life. Learn more at **nasponline.org**.

The Trevor Project

Is the world's largest suicide prevention and crisis intervention organization for LGBTQ (Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning) young people. The organization works to save young lives by providing support through free and confidential suicide prevention and crisis intervention programs on platforms where young people spend their time, including a 24/7 phone lifeline, chat, text and soon-to-come integrations with social media platforms. The organization also runs TrevorSpace, the world's largest safe space social networking site for LGBTQ youth, and operates innovative education, research, and advocacy programs. Learn more at **TheTrevorProject.org**.

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Introduction

This document outlines model policies and best practices for school districts to follow to protect the health and safety of all students. In 2017, suicide was the second leading cause of death among young people ages 10-19.[1] It is critically important that school districts have policies and procedures in place to prevent, assess the risk of, intervene, and respond to youth suicidal behavior.

Protecting the health and well-being of students is in line with school mandates and is an ethical imperative for all professionals working with youth. Because it is impossible to predict when a crisis will occur, preparedness is necessary for every school district. Furthermore, prevention programs and policies can help to deter suicide, rather than just acting in response. On average, a young person dies by suicide every hour and 25 minutes in the U.S.[2] For every young person who dies by suicide, an estimated 100-200 youth make suicide attempts.[3] Youth suicide is preventable, and educators and schools are key to prevention.

This document was developed by examining strong local policies, ensuring that they are in line with the latest research in the field of suicide prevention, and identifying best practices for a national framework. The model is comprehensive, yet the policy language is modular and may be used to draft your own district policy based upon the unique needs of your district.

The language and concepts covered by this policy are applicable for education levels K-12. While historically, many school-based suicide prevention policies have focused on middle and high school students – and that framework serves as the basis for much of this guide – current data has shown an increased (albeit still low) suicide rate for children at younger ages. Keeping in mind that a student talking about suicide must be taken seriously at any age, much of the information is relevant for elementary schools as well as older students. As emphasized in the National Strategy for Suicide Prevention, preventing suicide depends not only on suicide prevention policies, but also on a holistic approach. This approach promotes a wellness culture that encompasses multiple dimensions, including social and mental health, and the participation of families and communities.[4] Thus, this model policy is intended to be paired with other policies and efforts that support the emotional and behavioral well-being of youth.

Please refer to the **Resources** section in this guide for additional information. If you would like support in writing a policy for your own district or have questions, please contact the Advocacy and Government Affairs Department at The Trevor Project (202-204-4730, **Advocacy@TheTrevorProject.org**), or the American Foundation for Suicide Prevention's Prevention Education Department (**education@afsp.org**).

Model Policy Language

Purpose

The purpose of this policy is to protect the health and well-being of all students by having procedures in place to prevent, assess the risk of, intervene in, and respond to suicide. The district:

- Recognizes that physical and mental health are integral components of student outcomes, both educationally and beyond graduation
- Further recognizes that suicide is a leading cause of death among young people
- Has an ethical responsibility to take a proactive approach in preventing deaths by suicide
- Acknowledges the school's role in providing an environment that is sensitive to individual and societal factors that place youth at greater risk for suicide and helps to foster positive youth development and resilience
- Acknowledges that comprehensive suicide prevention policies include prevention, intervention, and postvention components

This policy is meant to be paired with other policies supporting the overall emotional and behavioral health of students.

Scope

This policy covers actions that take place in the school, on school property, at school-sponsored functions and activities, on school buses or vehicles and at bus stops, and at school-sponsored out-of-school events where school staff are present. This policy applies to the entire school community, including educators, school and district staff, students, parents/guardians, and volunteers. This policy also covers appropriate school responses to suicidal or high-risk behaviors that take place outside of the school environment.

Definitions

At-Risk

Suicide risk is not a dichotomous concern, but rather, exists on a continuum with various levels of risk. Each level of risk requires a different level of response and intervention by the school and the district. A student who is defined as high-risk for suicide is one who has made a suicide attempt, has the intent to die by suicide, or has displayed a significant change in behavior suggesting the onset of potential mental health conditions or a deterioration of mental health. The student may have thoughts about suicide, including potential means of death, and may have a plan. In addition, the student may exhibit behaviors or feelings of isolation, hopelessness, helplessness, and the inability to tolerate any more pain. This situation would necessitate a referral, as documented in the following procedures. The type of referral, and its level of urgency, shall be determined by the student's level of risk – according to local district policy.

Crisis Team

A multidisciplinary team of administrative staff, mental health professionals, safety professionals, and support staff whose primary focus is to address crisis preparedness, intervention, response and recovery. Crisis Team members often include someone from the administrative leadership, school psychologists, school counselors, school social workers, school nurses, resource police officer, and others including support staff and/or teachers. These professionals have been specifically trained in areas of crisis preparedness and take a leadership role in developing crisis plans, ensuring school staff can effectively execute various crisis protocols, and may provide mental health services for effective crisis interventions and recovery supports. Crisis team members who are mental health professionals may provide crisis intervention and services.

Mental Health

A state of mental, emotional, and cognitive health that can impact perceptions, choices and actions affecting wellness and functioning. Mental health conditions include depression, anxiety disorders, post-traumatic stress disorder (PTSD), and substance use disorders. Mental health can be impacted by the home and social environment, early childhood adversity or trauma, physical health, and genes.

Risk Assessment

An evaluation of a student who may be at-risk for suicide, conducted by the appropriate designated school staff (e.g., school psychologist, school social worker, school counselor, or in some cases, trained school administrator). This assessment is designed to elicit information regarding the student's intent to die by suicide, previous history of suicide attempts, presence of a suicide plan and its level of lethality and availability, presence of support systems, and level of hopelessness and helplessness, mental status, and other relevant risk factors.

Risk Factors for Suicide

Characteristics or conditions that increase the chance that a person may attempt to take their life. Suicide risk is most often the result of multiple risk factors converging at a moment in time. Risk factors may encompass biological, psychological, and/or social factors in the individual, family, and environment. The likelihood of an attempt is highest when factors are present or escalating, when protective factors and healthy coping techniques have diminished, and when the individual has access to lethal means.

Self-Harm

Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Self-harm behaviors can be either non-suicidal or suicidal. Although non-suicidal self-injury (NSSI) lacks suicidal intent, youth who engage in any type of self-harm should receive mental health care. Treatment can improve coping strategies to lower the urge to self-harm, and reduce the long-term risk of a future suicide attempt.

Suicide

Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.

NOTE: The coroner's or medical examiner's office must first confirm that the death was a suicide before any school official may state this as the cause of death. Additionally, parent or guardian preference shall be considered in determining how the death is communicated to the larger community.

Suicide Attempt

A self-injurious behavior for which there is evidence that the person had at least some intent to die. A suicide attempt may result in death, injuries, or no injuries. A mixture of ambivalent feelings, such as a wish to die and a desire to live, is a common experience with most suicide attempts. Therefore, ambivalence is not a reliable indicator of the seriousness or level of danger of a suicide attempt or the person's overall risk.

Suicidal Behavior

Suicide attempts, injury to oneself associated with at least some level of intent, developing a plan or strategy for suicide, gathering the means for a suicide plan, or any other overt action or thought indicating intent to end one's life.

Suicidal Ideation

Thinking about, considering, or planning for self-injurious behavior that may result in death. A desire to be dead without a plan or the intent to end one's life is still considered suicidal ideation and shall be taken seriously.

Suicide Contagion

The process by which suicidal behavior or a suicide completion influences an increase in the suicide risk of others. Identification, modeling, and guilt are each thought to play a role in contagion. Although rare, suicide contagion can result in a cluster of suicides within a community.

Postvention

Suicide postvention is a crisis intervention strategy designed to assist with the grief process following suicide loss. This strategy, when used appropriately, reduces the risk of suicide contagion, provides the support needed to help survivors cope with a suicide death, addresses the social stigma associated with suicide, and disseminates factual information after the death of a member of the school community. Often a community or school's healthy postvention effort can lead to readiness to engage further with suicide prevention efforts and save lives.

Prevention

District Policy Implementation

A district-level suicide prevention coordinator shall be appointed by the superintendent or designee. The district suicide prevention coordinator and building principal shall be responsible for planning and coordinating implementation of this policy for the school district. Each school principal shall designate a school suicide prevention coordinator to act as a point of contact in each school for issues relating to suicide prevention and policy implementation. This may be an existing staff person. All staff members shall report students they believe to be at-risk for suicide to the school suicide prevention coordinator or appropriate school mental health professional if the coordinator is unavailable.

Staff Professional Development

All staff shall receive, at minimum, annual professional development on risk factors, warning signs, protective factors, response procedures, referrals, postvention, and resources regarding youth suicide prevention. The professional development shall include additional information regarding groups of students at elevated risk for suicide, including those living with mental and/or substance use disorders, those who engage in self-harm or have attempted suicide, those in out-of-home settings (e.g., youth in foster care, group homes, incarcerated youth), those experiencing homelessness, American Indian/Alaska Native students, LGBTQ (Lesbian, Gay, Bisexual, Transgender, Queer and Questioning) students, students bereaved by suicide, and those with medical conditions or certain types of disabilities. Additional professional development in risk assessment and crisis intervention shall be provided to school-employed mental health professionals and school nurses.

Youth Suicide Prevention Programming

Developmentally appropriate, student-centered education materials shall be integrated into the curriculum of all K-12 health classes and other classes as appropriate. The content of these age-appropriate materials shall include the importance of safe and healthy choices and coping strategies focused on resiliency building, and how to recognize risk factors and warning signs of mental health conditions and suicide in oneself and others. The content shall also include help-seeking strategies for oneself or others and how to engage school resources and refer friends for help. In addition, schools shall provide supplemental small-group suicide prevention programming for students. It is not recommended to deliver any programming related to suicide prevention to a large group in an auditorium setting.

Publication and Distribution

This policy shall be distributed annually and be included in all student and teacher handbooks, and on the school website. All school personnel are expected to know and be accountable for following all policies and procedures regarding suicide prevention.

Intervention

Assessment and Referral

When a student is identified by a peer, educator or other source as potentially suicidal – i.e., verbalizes thoughts about suicide, presents overt risk factors such as agitation or intoxication, an act of self-harm occurs, or expresses or otherwise shows signs of suicidal ideation – the student shall be seen by a school-employed mental health professional, such as a school psychologist, school counselor, school social worker, within the same school day to assess risk and facilitate referral if necessary. Educators shall also be aware of written threats and expressions about suicide and death in school assignments. Such incidences require immediate referral to the appropriate school-employed mental health professional. If there is no mental health professional available, a designated staff member (e.g., school nurse or administrator) shall address the situation according to district protocol until a mental health professional is brought in.

For At-Risk Youth

- School staff shall continuously supervise the student to ensure their safety until the assessment process is complete
- The principal and school suicide prevention coordinator shall be made aware of the situation as soon as reasonably possible
- The school-employed mental health professional or principal shall contact the student's parent or guardian, as described in the **Parental Notification Involvement** section and in compliance with existing state law/ district policy (if applicable), and shall assist the family with urgent referral
- Urgent referral may include, but is not limited to, working with the parent or guardian to set up an outpatient mental health or primary care appointment and conveying the reason for referral to the healthcare provider; in some instances, particularly life-threatening situations, the school may be required to contact emergency services, or arrange for the student to be transported to the local Emergency Department, preferably by a parent or guardian
- If parental abuse or neglect is suspected or reported, the appropriate state protection officials (e.g., local Child Protection Services) shall be contacted in lieu of parents as per law
- Staff will ask the student's parent or guardian, and/or eligible student, for written permission to discuss the student's health with outside care providers, if appropriate

When School Personnel Need to Engage Law Enforcement

A school's crisis response plan shall address situations when school personnel need to engage law enforcement. When a student is actively suicidal and the immediate safety of the student or others is at-risk (such as when a weapon is in the possession of the student), school staff shall call 911 immediately. The staff calling shall provide as much information about the situation as possible, including the name of the student, any weapons the student may have, and where the student is located. School staff may tell the dispatcher that the student is a suicidal emotionally disturbed person, or "suicidal EDP", to allow for the dispatcher to send officers with specific training in crisis de-escalation and mental illness.

Parental Notification and Involvement

Disclaimer: Reporting requirements, parental rights and school responsibilities related to referrals may vary from state to state. For example, if a school district advises a parent that the child must be examined by a mental health professional prior to returning to school, then the district may be required to pay for the costs of such medical treatment. School districts should consult with their board attorney regarding parental notification and involvement and school responsibility for referrals.

The principal, designee, or school mental health professional shall inform the student's parent or guardian on the same school day, or as soon as possible, any time a student is identified as having any level of risk for suicide or if the student has made a suicide attempt (pursuant to school/state codes, unless notifying the parent will put the student at increased risk of harm). Following parental notification and based on initial risk assessment, the principal, designee, or school mental health professional may offer recommendations for next steps based on perceived student need. These can include but are not limited to, an additional, external mental health evaluation conducted by a qualified health professional or emergency service provider.

When a student indicates suicidal intent, schools shall attempt to discuss safety at home, or "means safety" with parent or guardian, limiting the student's access to mechanisms for carrying out a suicide attempt e.g., guns, knives, pills, etc. In addition, during means counseling, which can also include safety planning, it is imperative to ask parents whether or not the individual has access to a firearms, medication or other lethal means.

Lethal means counseling shall include discussing the following[5]:

Firearms

- Inquire of the parent or guardian if firearms are kept in the home or are otherwise accessible to the student
- Recommend that parents store all guns away from home while the student is struggling – e.g., following state laws, store their guns with a relative, gun shop, or police
- Discuss parents' concerns and help problem-solve around offsite storage, and avoid a negative attitude about guns – accept parents where they are, but let them know offsite storage is an effective, immediate way to protect the student
- Explain that in-home locking is not as safe as offsite storage, as children and adolescents sometimes find the keys or get past the locks
    - If there are no guns at home:
        - Ask about guns in other residences (e.g., joint custody situation, access to guns in the homes of friends or other family members)
    - If parent won't or can't store offsite:
        - The next safest option is to unload guns, lock them in a gun safe, and lock ammunition separately (or don't keep ammunition at home for now)
        - If guns are already locked, ask parents to consider changing the combination or key location – parents can be unaware that the student may know their "hiding" places

Medications

- Recommend the parent or guardian lock up all medications (except rescue meds like inhalers), either with a traditional lock box or a daily pill dispenser
- Recommend disposing of expired and unneeded medications, especially prescription pain pills
- Recommend parent maintain possession of the student's medication, only dispensing one dose at a time under supervision

- If parent won't or can't lock medication, advise they prioritize and seek specific guidance from a doctor or pharmacist regarding the following:
    - Prescriptions, especially for pain, anxiety or insomnia
    - Over-the-counter pain pills
    - Over-the-counter sleeping pills

Staff will also seek parental permission, in the form of a Release of Information form, to communicate with outside mental health care providers regarding the student's safety plan and access to lethal means.

Re-Entry Procedure

For students returning to school after a mental health crisis (e.g., suicide attempt or psychiatric hospitalization), whenever possible, a school-employed mental health professional, the principal, or designee shall meet with the student's parent or guardian, and if appropriate, include the student to discuss re-entry. This meeting shall address next steps needed to ensure the student's readiness for return to school and plan for the first day back. Following a student hospitalization, parents may be encouraged to inform the school counselor of the student's hospitalization to ensure continuity of service provision and increase the likelihood of a successful re-entry.

1. A school-employed mental health professional or other designee shall be identified to coordinate with the student, their parent or guardian, and any outside health care providers. The school-employed mental health professional shall meet with the student and their parents or guardians to discuss and document a re-entry procedure and what would help to ease the transition back into the school environment (e.g., whether or not the student will be required to make up missed work, the nature of check-in/check-out visits, etc.). Any necessary accommodations shall also be discussed and documented.
2. While not a requirement for re-entry, the school may coordinate with the hospital and any external mental health providers to assess the student for readiness to return to school.
3. The designated staff person shall periodically check-in with the student to help with readjustment to the school community and address any ongoing concerns, including social or academic concerns.
4. The school-employed mental health professional shall check-in with the student and the student's parents or guardians at an agreed upon interval depending on the student's needs either on the phone or in person for a mutually agreed upon time period (e.g. for a period of three months). These efforts are encouraged to ensure the student and their parents or guardians are supported in the transition, with more frequent check-ins initially, and then fading support.
5. The administration shall disclose to the student's teachers and other relevant staff (without sharing specific details of mental health diagnoses) that the student is returning after a medically-related absence and may need adjusted deadlines for assignments. The school-employed mental health professional shall be available to teachers to discuss any concerns they may have regarding the student after re-entry.

For more detailed information on **Points to Consider When Developing Re-Entry Policies**, please see page 21 within the Commentary section of this document.

In-School Suicide Attempts

In the case of an in-school suicide attempt, the physical and mental health and safety of the student are paramount. In these situations:

1. First aid shall be rendered until professional medical services and/or transportation can be received, following district emergency medical procedures
2. School staff shall supervise the student to ensure their safety
3. Staff shall move all other students out of the immediate area as soon as possible
4. The school-employed mental health professional or principal shall contact the student's parent or guardian. (Note: See **Parental Notification and Involvement** section of this document).
5. Staff shall immediately notify the principal or school suicide prevention coordinator regarding the incident of in-school suicide attempt
6. The school shall engage the crisis team as necessary to assess whether additional steps should be taken to ensure student safety and well-being, including those students who may have had emotional or physical proximity to the victim
7. Staff shall request a mental health assessment for the student as soon as possible

Since self-harm behaviors are on a continuum of level and urgency, not all instances of suicidal ideation or behavior warrant hospitalization. A mental health assessment, including a suicide risk assessment, can help determine the best treatment plan and disposition.

Out-of-School Suicide Attempts

If a staff member becomes aware of a suicide attempt by a student that is in progress in an out-of-school location, the staff member shall:

1. Call 911 (police and/or emergency medical services)
2. Inform the student's parent or guardian
3. Inform the school suicide prevention coordinator and principal

If the student contacts the staff member and expresses suicidal ideation, the staff member shall maintain contact with the student (either in person, online, or on the phone) and then enlist the assistance of another person to contact the police while maintaining engagement with the student.

After a Suicide Death

Development and Implementation of a Crisis Response Plan

The crisis response team, led by a designated crisis response coordinator, shall develop a crisis response plan to guide school response following a death by suicide. This plan may be applicable to all school community related suicides whether it be student (past or present), staff, or other prominent school community member. Ideally, this plan shall be developed long before it is needed. A meeting of the crisis team to implement the plan shall take place immediately following word of the suicide death, even if the death has not yet been confirmed to be a suicide.

For more detailed information on responding to a suicide death, please see the document ***After A Suicide: A Toolkit for Schools***, which was revised in 2018.

Action Plan Steps

Step 1: Get the Facts

The crisis response coordinator or other designated school official (e.g. the school's principal or superintendent) shall confirm the death and determine the cause of death through communication with the student's parent or guardian, the coroner's office, local hospital, or police department. Before the death is officially classified as a suicide by the coroner's office, the death shall be reported to staff, students, and parents or guardians, with an acknowledgement that its cause is unknown. When a case is perceived as being an obvious instance of suicide, it shall not be labeled as such until after a cause of death ruling has been made. If the cause of death has been confirmed as suicide but the parent or guardian prefers the cause of death not be disclosed, the school may release a general statement without disclosing the student's name (e.g., "We had a ninth-grade student die over the weekend"). If the parents do not want to disclose cause of death, an administrator or mental health professional from the school who has a good relationship with the family shall be designated to speak with the parents to explain the benefits of sharing mental health resources and suicide prevention with students. If the family refuses to permit disclosure, schools may state "The family has requested that information about the cause of death not be shared at this time." Staff may also use the opportunity to talk with students about suicide.

Step 2: Assess the Situation

The crisis response team shall meet to prepare the postvention response according to the crisis response plan. The team shall consider how the death is likely to affect other students, and determine which students are most likely to be affected. The crisis response team shall also consider how recently other traumatic events have occurred within the school community and the time of year of the suicide. The team and principal shall triage staff first, and all teachers directly involved with the victim shall be notified in-person and offered the opportunity for support.

Another consideration related to communication after a suicide death involves educating parents and other adults on suicide grief, since adult behavior following a suicide death can have a great impact on students, particularly elementary school-aged students.

Step 3: Share Information

Inform the faculty and staff that a sudden death has occurred, preferably in an all-staff meeting. The crisis response team shall provide a written statement for staff members to share with students and also assess staff's readiness to provide this message in the event a designee is needed. The statement shall include the basic facts of the death and known funeral arrangements (without providing details of the suicide method), recognition of the sorrow the news will cause, and information about the resources available to help students cope with their grief. Staff shall respond to questions only with factual information that has been confirmed. Staff shall dispel rumors with facts, be flexible with academic demands, encourage conversations about suicide and mental health, normalize a wide range of emotional reactions, and know the referral process and how to get help for a student. Avoid public address system announcements and school-wide assemblies in favor of face-to-face notifications, including small-group and classroom discussions. The crisis response team may prepare a letter – with the input and permission from the student's parent or guardian – to communicate with parents which includes facts about the death, information about what the school is doing to support students, the warning signs of suicidal behavior, and a list of resources available. If necessary, a parent meeting may also be planned. Staff shall direct all media inquiries to the designated school or district spokesperson.

Step 4: Avoid Suicide Contagion

Actively triage particular risk factors for contagion, including emotional proximity (e.g., siblings, friends, or teammates), physical proximity (witness, neighbor) and pre-existing mental health issues or trauma. Explain in an all-staff meeting that one purpose of trying to identify and provide services to other high-risk students is to prevent another death. The crisis response team shall work with teachers to identify students who are most likely to be significantly affected by the death, or who exhibit behavioral changes indicating increased risk. In the staff meeting, the crisis response team shall review suicide warning signs and procedures for referring students who present with increased risk. For those school personnel who are concerned that talking about suicide may contribute to contagion, it has been clearly demonstrated through research that talking about mental health and suicide in a nonjudgmental, open way that encourages dialogue and help-seeking does not elevate risk.

Step 5: Initiate Support Services

Students identified as being more likely to be affected by the death will be assessed by a school mental health professional to determine the level of support needed. The crisis response team shall coordinate support services for students and staff in need of individual and small group counseling as needed. School-employed mental health professionals will provide on-going and long term support to students impacted by the death of the student, as needed. If long term intensive services by a community provider are warranted, the school-employed mental health professional will collaborate with that provider and the family to ensure continuity of care between the school, home, and community. Together with parents or guardians, crisis response team members shall provide information for partner community mental health providers, or providers with appropriate expertise, to ensure a smooth transition from the crisis intervention phase to meeting underlying or ongoing mental health needs. These discussions may include debriefing (orientation to the facts), reflection on memories, reminders for and re-teaching of coping skills, and encouraging spending time with friends and caregivers as soon as possible. Students and staff affected by the suicide death shall be encouraged to return to a normal routine as much as possible, understanding that some deviation from routine is to be expected.

Step 6: Develop Memorial Plans

The school shall develop policy regarding memorialization due to any cause and strive to treat all deaths the same way. Avoid planned on-campus physical memorials (e.g. photos, flowers, locker displays), funeral services, tributes, or flying the flag at half-staff, because it may inadvertently sensationalize the death and encourage suicide contagion among vulnerable students. Spontaneous memorials may occur from students expressing their grief. Cards, letters, and pictures may be given to the student's family after being reviewed by school administration. If items indicate that additional students may be at increased risk for suicide and/or in need of additional mental health support (e.g. writing about a wish to die or other risk behavior), outreach shall be made to those students to help determine level of risk and appropriate response.

The school shall also leave a notice for when the memorial will be removed and given to the student's family. Online memorial pages shall use safe messaging, include resources to obtain information and support, be monitored by an adult, and be time limited. School shall not be canceled for the funeral or for reasons related to the death. Any school-based memorials (e.g., small gatherings) shall include a focus on how to prevent future suicides and prevention resources available.

For more information on memorials after a death, please refer to the Memorialization section (pgs. 25-31) of the document ***After a Suicide: A Toolkit for Schools***.

It is noteworthy that even articles that are inappropriate to share with families may have been therapeutic for the students to create. Allowing for these memorials to stay in place for a brief period up to the funeral (up to approximately five days), and monitoring memorials while in place, is recommended to avoid hostile and glamorizing messaging and to monitor for at-risk students.

Step 7: Postvention as Prevention

Following a student suicide, schools may take the initiative to review and/or revise existing policies.

External Communication

The school or district-appointed spokesperson shall be the sole media spokesperson. Staff shall refer all inquiries from the media directly to the spokesperson. The spokesperson shall:

- Keep the district superintendent and school crisis response coordinator informed of school actions relating to the death
- Prepare a statement for the media, which may include the facts of the death, postvention plans, and available resources – the statement shall not include confidential information, speculation about victim motivation, means of suicide, or personal family information

The school or district-appointed spokesperson shall answer all media inquiries. If a suicide is to be reported by news media, the spokesperson shall encourage reporters to follow safe messaging guidelines (e.g. not to make it a front-page story, not to use pictures of the suicide victim, not to use the word suicide in the caption of the story, not to describe the method of suicide, and not to use the phrase "suicide epidemic") to mitigate the risk of suicide contagion. The spokesperson shall encourage media not to link bullying to suicide, and not to speculate about the reason for suicide and instead offer the community information on suicide risk factors, warning signs, and resources available.

Sample Language for Student Handbook

Protecting the health and well-being of all students is of utmost importance to the school district. The school board has adopted a suicide prevention policy which will help to protect all students through the following steps:

- Students will learn about recognizing and responding to warning signs of suicide in friends, using coping skills, support systems, and seeking help for themselves and friends. This curricular content will occur in all health classes throughout the school year, not just in response to a suicide, and the encouragement of help-seeking behavior will be promoted at all levels of the school leadership and stakeholders
- Each school or district will designate a suicide prevention coordinator to serve as a point of contact for students in crisis and to refer students to appropriate resources
- When a student is identified as being at-risk, a risk assessment will be completed by a trained school staff member who will work with the student and help connect the student to appropriate local resources
- Students will have access to national resources that they can contact for additional support, such as:
  - National Suicide Prevention Lifeline: 1-800-273-TALK (8255)
    suicidepreventionlifeline.org
  - The Trevor Lifeline: 1-866-488-7386
    thetrevorproject.org/get-help-now
  - **Trevor Lifeline Text/Chat Services, available 24/7**
    Text "TREVOR" to 678-678
  - Crisis Text Line: Text TALK to 741-741
    crisistextline.org

All school personnel and students will be expected to help create a school culture of respect and support, in which students feel comfortable seeking help for themselves or friends. Students are encouraged to tell any staff member if they or a friend are feeling suicidal, or are in need of help.

While confidentiality and privacy are important, students should know that when there is risk of suicide, safety comes first.

For a more detailed review of policy changes, please see the district's full suicide prevention policy.

Commentary

Parental Involvement

Parents and guardians play a key role in youth suicide prevention, and it is important for the school district to involve them in suicide prevention efforts. While parents and guardians need to be informed and actively involved in decisions regarding the student's welfare, the school mental health professional should ensure that the parents' actions are in the best interest of the student (e.g., when a student is LGBTQ and living in an unaffirming household). Parents and guardians who learn the warning signs and risk factors for suicide are better equipped to connect their children with professional help when necessary. Parents and guardians should be advised to take every statement regarding suicide and a wish to die seriously, and avoid assuming that the student is simply seeking attention. There are commercially available videos and programs to help train parents in recognizing suicide warning signs.

Parents and guardians can also contribute to important protective factors – conditions that reduce vulnerability to suicidal behavior – for all students, especially vulnerable youth populations such as LGBTQ youth. Recent research shows that LGBT youth who are rejected by their parents are at a much higher risk of depression, suicide, illegal drug use, and unprotected sexual practices. Conversely, acceptance and support by family results in higher levels of self-esteem, lower levels of suicidal ideation and self-harm incidents, and better overall physical health.[6]

Special Considerations

If the school district advises a parent that the student must be examined by a mental health professional prior to the student returning to school, then the district may be required to pay for the costs of such medical treatment depending upon state requirements. In addition, if a student with a documented disability is prevented from returning to school until cleared by a mental health professional, the school district is expected to file for an expedited hearing pursuant to the Individuals with Disabilities in Education Act (IDEA); the parent is entitled to all due process rights available under IDEA. If the parent does not follow through with the school's recommendation and the student's perceived risk persists, the school shall follow state/district legal or policy requirements to ensure student safety. This may include a range of suggested options for next steps – call 911, call Child Protective Services, call mobile crisis services, etc.

When a parent is notified of perceived suicide risk or an attempt, it is essential that the school maintain student confidentiality related to personal information such as sexual orientation or gender identity, especially when the student has not already disclosed to the parent or guardian and does not want it shared. Information shared should be restricted to the perceived risk of suicide or facts of the attempt. Ethically and legally, mental health professionals are required to report risk to self and others. Disclosing a student's sexual orientation or gender identity without their explicit consent can in some cases endanger the student and at a minimum will impair the rapport developed with the professional.

Through discussion with the student, the principal or school-employed mental health professional will assess whether there is further risk of harm due to parent or guardian notification. If the principal, designee, or mental health professional believes, in their professional capacity, that contacting the parent or guardian would endanger the health or well-being of the student, they may delay such contact as appropriate. Consultation with another mental health professional is recommended before taking such inaction. If contact is delayed, the reasons for the delay should be documented. Legally, the parent should not be contacted and Child Protection Services should be notified if abuse or neglect is suspected.

Importance of School-Based Mental Health Supports

Access to school-employed mental health resources and access to school-based mental health supports directly improves students' physical and psychological safety, academic performance, cognitive performance and learning, and social/emotional development. School-employed mental health professionals (school counselors, school psychologists, school social workers, and in some cases, school nurses) ensure that resources are high quality, effective, and developmentally appropriate to the school context. School-employed mental health professionals are specially trained in the interconnectivity among school law, school system functioning, learning, mental health, and family systems. This training ensures that mental health resources are properly and effectively infused into the learning environment. These professionals can support both instructional leaders' and teachers' abilities to provide a safe school setting and the optimum conditions for teaching and learning.

Having these professionals as integrated members of the school staff empowers principals and administrators to more efficiently and effectively deploy resources, ensure coordination of resources, evaluate their effectiveness, and adjust supports to meet the dynamic needs of their student populations. Improving access also allows for enhanced collaboration with community providers to meet the more intense or clinical needs of students.[7]

Each school should provide important suicide prevention information on their website that includes local and national crisis resources, the warning signs of suicide, and who to contact for the school district if a parent or student is concerned about someone being suicidal.

Risk Factors and Protective Factors

Risk Factors for Suicide

Risk factors are characteristics or conditions that increase the chance that a person may try to attempt suicide. Suicide risk tends to be highest when someone has several risk factors at the same time, or has long standing risk factors and experiences a sudden or devastating setback. These factors interact, and the more there are and the more they intensify, the greater the risk.

The most frequently cited risk factors for suicide are:

- Mental health conditions:
  - Major depression (feeling down, withdrawn or agitated in a way that impacts daily life)
  - Bipolar disorder (exteme mood swings)
  - Substance use disorders (alcohol, prescribed and illicit drugs)
  - Anxiety disorders (excessive worry, obsessions or panic attacks)
  - Eating disorders

- Hopelessness
- Problems with alcohol or drugs
- Past suicide attempt(s)
- Family history of suicide or mental health problems
- Problems with impulse control and aggression
- Serious medical condition and/or pain
- Personality traits that create a pattern of intense, unstable relationships, or trouble with the law
- Psychosis, i.e., marked change in behavior, unusual thoughts, and behavior or confusion about reality
- History of early childhood trauma, abuse, neglect, or loss
- Current family stress or transitions
- History of head trauma

Protective Factors for Suicide

Protective factors are characteristics or conditions that may help to decrease a person's suicide risk. Protective factors for suicide have not been studied as thoroughly as risk factors, so less is known about them. These factors do not eliminate the possibility of suicide, especially in someone with risk factors. Protective factors help to create resiliency, or an ability to "bounce back" from setbacks encountered throughout life.

Protective factors for suicide include:

- Receiving effective mental health care
- Positive connections to family, peers, and community
- Access to welcoming and affirming faith-based institutions, supportive social groups and clubs
- Presence of healthy role models
- Development of coping mechanisms, safety plans, and self-care strategies
- The skills and ability to solve problems
- Cultural, spiritual, or faith-based beliefs that promote connections and help-seeking

Note that protective factors do not entirely remove risk, but can mitigate against risk. There are brief periods when students with strong protective factors can have them temporarily dismantled by an acute stressor or sudden increase in other risk factors (e.g., if depression worsens, a student's usual positive coping skills and resilience may diminish).

At-Risk Student Populations

It is important for school districts to be aware of student populations that are at elevated risk for suicidal behavior based on various factors.

Youth Living with Mental and/or Substance Use Disorders

Mental health conditions, in particular depression/dysthymia, attention-deficit hyperactivity disorder, eating disorders, intermittent explosive disorder, and conduct disorder are important risk factors for suicidal behavior among young people.[8] An estimated one in four to five children have a diagnosable mental condition that

will cause severe impairment, with the average onset of depression and dysthymia occurring between ages 11 and 14 years[9]; therefore, school staff may play a pivotal role in recognizing and referring the student to treatment that may reduce risk and enhance overall performance and improve long-term outcomes. Though mental health conditions are a risk factor for suicide, the majority of people with mental health concerns do not engage in suicidal behavior.

Youth Who Engage in Self-Harm or Have Attempted Suicide

Suicide risk is significantly higher among those who engage in non-suicidal self-harm than among the general population. Whether or not they report suicidal intent, one study found that 70 percent of adolescents admitted into inpatient psychiatric treatment who engage in self-harm report attempting suicide at least once in their life.[10] Additionally, a previous suicide attempt is a known powerful risk factor for suicide death. One study found that as many as 88 percent of people who attempt suicide for the first time and are seen in the Emergency Department go on to attempt suicide again within two years.[11] Many adolescents who attempt suicide do not receive necessary follow-up care for many reasons, including limited access to resources (transportation, insurance, copays, parental consent, etc.).

Youth in Out-of-Home Settings

Youth involved in the juvenile justice or child welfare systems have a high prevalence of risk factors for suicide. As much as 60 to 70 percent of young people involved in the juvenile justice system meet criteria for at least one psychiatric disorder, and youth in juvenile justice residential programs are three times more likely to die by suicide than the general youth population.[12] According to a study released in 2018, nearly a quarter of youth in foster care had a diagnosis of major depression in the last year. Additionally, a quarter of foster care youth reported attempting suicide by the time they were 17.5 years old.[13]

Youth Experiencing Homelessness

For youth experiencing homelessness, the rate of self-injury, suicidal ideation, and suicide attempts is over two times greater than those of the adolescent population in general.[14] These young people also have higher rates of mood disorders, conduct disorder, and post-traumatic stress disorder. One study found that more than half of runaway and homeless youth experience suicidal ideation.[15]

American Indian/Alaska Native (AI/AN) Youth

In 2017, the rate of suicide among AI/AN youth ages 15-19 was over 1.6 times that of the general youth population.[16] Risk factors that can affect this group include substance use, discrimination, lack of access to mental health care, and historical trauma. For more information about historical trauma and how it can affect AI/AN youth, see **ihs.gov/suicideprevention**.

LGBTQ (Lesbian, Gay, Bisexual, Transgender, Queer or Questioning) Youth

The CDC finds that LGB youth are 4.5 times more likely, and questioning youth are over twice as likely to consider attempting suicide as their heterosexual peers.[17] One study found that 40 percent of transgender people attempted suicide sometime in their lifetime – of those who attempted, 73 percent made their first attempt before the age of 18.[18] Suicidal behavior among LGBTQ youth can be related to experiences of discrimination, family rejection, harassment, bullying, violence, and victimization. For those youth with baseline risk for suicide (especially those with a mental health condition), these experiences can place them at increased risk. It is not their sexual orientation or gender identity that place LGBTQ youth at greater risk of suicidal behavior, but rather these societal and external factors: the way they are treated, shunned, abused, or neglected, in concert with other individual factors such as mental health history.

Youth Bereaved by Suicide

Studies show that those who have experienced suicide loss, through the death of a friend or loved one, are nearly four times as likely to attempt suicide themselves.[19]

Youth Living with Medical Conditions or Disabilities

A number of physical conditions are associated with an elevated risk for suicidal behavior. Some of these conditions include chronic pain, loss of mobility, disfigurement, cognitive delays that make problem-solving a challenge, and other chronic limitations. Adolescents with asthma are more likely to report suicidal ideation and behavior than those without asthma. Additionally, studies show that suicide rates are significantly higher among people with certain types of disabilities, such as those with multiple sclerosis or spinal cord injuries.[20]

Best Practice: Suicide Prevention Task Force

It is recommended that school districts establish a suicide prevention task force in conjunction with adopting a suicide prevention policy. Such a task force should consist of administrators, parents, teachers, school-employed mental health professionals, representatives from community suicide prevention services, and other individuals with expertise in youth mental health, under the administration of a district suicide prevention coordinator. The purpose of such a task force is to provide advice to the district administration and school board regarding suicide prevention activities and policy implementation, and to keep aware of current research, data, trends, and evolving best practices. In addition, the task force can help to compile a list of community resources to assist with suicide prevention activities and referrals to community mental health providers.

Referrals and LGBTQ Youth

LGBTQ youth are at heightened risk for suicidal behavior, which may be related to experiences of discrimination, family rejection, harassment, bullying, violence, and victimization. It is therefore especially important that school staff be trained to support at-risk LGBTQ youth with sensitivity, cultural competency, and affirming practices. School staff should not make assumptions about a student's sexual orientation or gender identity, and should validate students who do decide to disclose this information. Information about a student's sexual orientation or gender identity should be treated as confidential and not disclosed to parents, guardians, or third parties without the student's permission. In the case of parents who have exhibited rejecting behaviors, great sensitivity needs to be taken in what information is communicated with parents. Additionally, when referring students to out-of-school resources, it is important to connect LGBTQ students with LGBTQ-affirming local health and mental health service providers. Affirming service providers are those that adhere to best practices guidelines regarding working with LGBTQ clients as specified by their professional association (e.g., **apa.org/pi/lgbt/resources/guidelines.aspx**).

Bullying and Suicide

The relationship between bullying and suicide is highly complex, as is the relationship between suicide and other negative life events. Research indicates that persistent bullying can lead to or worsen feelings of isolation, rejection, exclusion and despair, as well as depression and anxiety, which can contribute to suicidal behavior in those at-risk.[21]

While studies have shown that young people who are bullied and those who bully others are at heightened risk for suicidal behavior, youth who exhibit both pre-existing risk for suicide (e.g., a history of depression, anxiety, substance use or other health conditions) and who are concurrently involved in bullying or experiencing other negative life events are at highest risk.[22] Individuals who are bullied in the absence of other risk factors have far fewer negative outcomes than those with pre-existing risk for suicide. Youth who bully are also at-risk, and their behavior may reflect underlying mental health problems or previous childhood trauma. One study found that those who are bullied (cyber or in person) are 19 times more likely to experience suicidal ideation than youth with no history of bullying.[23]

It is imperative to convey safe and accurate messages about bullying and suicide to youth, especially to young people who may be at-risk for suicide. Suggesting that suicide is a natural response to bullying, or providing repeated opportunities for at-risk students to see their own experiences of bullying, isolation, or exclusion reflected in stories of those who have died by suicide, can increase contagion risk by contributing to thoughts that frame suicide as a viable solution. Idealizing young people who complete suicide after being bullied or creating an aura of celebrity around them may contribute to an at-risk student's illogical thoughts that suicide is the only way to have a voice or to make a difference for others. However, when school personnel know that a student is involved in bullying, they should not hesitate to ask students direct questions about thoughts of suicide.

Whenever possible, discussions on bullying and suicide should center on prevention and resiliency, not statistics, and should encourage help-seeking behavior.

Points to Consider When Developing Re-Entry Policies

A school cannot require a student or their parents to provide documentation of a mental health assessment prior to re-entry following a mental health crisis. However, the following factors should be considered when determining local re-entry policy:

- Is there adequate availability of community-based mental health providers to ensure timely administration and documentation of student mental health status exam? (If not, the district is encouraged to have a school-employed mental health professional or trained administrator to conduct and document a suicide risk assessment to determine risk to self or others)
- Does the school have a relationship with local mental health agencies to help expedite the process in order to avoid long wait periods that could result in the student unnecessarily missing school?
- How are necessary education services and supports being provided to the student while they're out of school? (This is particularly important for students receiving special education services – schools should bear in mind, however, that most hospital programs only allow for a limited time devoted to school work and the vast majority of waking hours will be spent in therapy and/or learning coping techniques)

- Does the student experience suicidal ideation primarily outside of school? (If so, this would indicate that school is likely a safe space for the student)

In instances where a student is deemed suicidal but not taken for assessment by their parent or guardian, personnel should follow state/district legal or policy requirements to ensure student safety with consideration for referral to Child Protective Services for medical neglect.

Relevant State Laws

The following types of state laws can enhance a school's ability to effectively identify, intervene with, and support students at-risk for suicidal behavior.

Mandate Suicide Prevention Training for School Personnel

Training mandates help to ensure that all school staff members understand suicide risk and the referral process and have the skills and confidence to act when they suspect a student may be suicidal. Ideally, those mandates will apply to all school personnel who interact directly with students, not just licensed staff. Stronger state laws specify how much training is required and how often that training must occur (e.g., two hours, annually). Typically, states allow suicide prevention training hours to count toward any existing professional development or continuing education requirements for certification or licensure.

Mandate School Policies in Suicide Prevention, Intervention, and Postvention

Many states are now requiring school districts to create and implement a policy or protocol on suicide prevention, intervention, and postvention, to support existing mandates for school personnel training. Many also require the state department of education (or similar lead agency) to develop a model policy to assist school districts and to set minimum content requirements for district policies. This *Model School District Policy on Suicide Prevention* can be an ideal starting point for implementation of these laws.

Allow Youth Access to Mental Health Care

Some states require youth under age 18 to receive parental permission before seeking mental health care, while others limit mental health confidentiality, which can be an especially damaging problem for LGBTQ youth. Minor assent laws, which allow for those under the age of 18 to seek needed medical, mental health, and substance abuse care without parental consent, are imperative.

Ensure Anti-Bullying and Nondiscrimination Policies

While the majority of states have adopted some form of state-level anti-bullying and anti-harassment legislation, not all states specifically prohibit bullying and harassment on the basis of sexual orientation and gender identity. Visit **stopbullying.gov/laws** to find your state's current anti-bullying law and/or policy.

Eliminate Laws that Stigmatize, Isolate, or Allow for Criminalization of LGBTQ Youth

Typically referred to as "No Promo Homo" or "Don't Say Gay" laws, these policies ban educators from talking about LGBTQ people, issues or history, or only allow negative discussion. These laws keep supportive teachers

from speaking out in the classroom and may restrict or even eliminate vital safe spaces and affirming resources for LGBTQ youth, including activities, clubs, and discussions that support LGBTQ students. Research shows that schools that eliminate gender-based practices (e.g., battle of the sexes at pep rallies, gender-based dress requirements for school performances) provide a relatively more inclusive environment for LGBTQ students to feel welcome and affirmed.[24] Laws seeking to protect LGBTQ youth from the dangerous and discredited practice of conversion therapy are also important in affirming LGBTQ youth.

District Liability

Schools have been sued and found liable for failing to take proper action to protect students, and for failing to notify parents and guardians when a student's suicide risk was evident and an untoward outcome occurred. The key issues in court cases have been foreseeability and negligence, and have included cases in which schools did not warn parents and guardians about both verbal and written statements about suicide, as well as cases in which the school failed to provide supervision and counseling for at-risk students.[25]

Schools have a responsibility to intervene in situations in the school environment that exacerbate a student's risk, particularly when the risk was known to the school. Schools have been sued over more complex issues, such as school climate and failure to reduce bullying, that were claimed to contribute to the suicide of a student. As the U.S. Department of Education Office for Civil Rights has emphasized, schools have legal obligations under anti-discrimination laws. In most states, and under all professional organizations' ethical codes, once a school knows or reasonably should know of possible student harassment, it must take immediate action to investigate, take steps to end the harassment, eliminate a hostile environment, and prevent its recurrence.[26]

Messaging and Suicide Contagion

Research has shown a link between certain kinds of suicide-related media (including social media) coverage and increases in suicide deaths. Suicide contagion has been observed when the number of stories about individual suicides increases, or when a particular death is reported in great detail. The coverage of a suicide death being prominently featured in a media outlet or on social media, or headlines about specific deaths being framed dramatically have also been observed to contribute to suicide contagion.

Research also shows that suicide contagion can be avoided when the media reports on suicide responsibly, such as by following the steps outlined in "Recommendations for Reporting on Suicide" at **ReportingOnSuicide.org**, as well as through the National Association for School Psychologists media guideline: **Responsible Media Coverage of Crisis Events Impacting Children and Youth**.

Contagion can play a role in cases of self-harm behavior. These behaviors may originate with one student and can spread to other students through imitation. Because adolescents are especially vulnerable to the risk of contagion, in the case of a suicide death it is important to acknowledge the student's death in a way that does not inadvertently glamorize or romanticize either the student or the death. Schools can do this by seeking opportunities to emphasize the importance of seeking help for self or others when there is concern about underlying mental health issues, such as depression or anxiety, and provide resources on where to seek help. Although many people who die by suicide do have a diagnosible or known underlying mental health issue, schools can also help students understand the importance of recognizing the signs of suicide, building

resiliency and coping skills, and helping to decrease the stigma associated with seeking help for mental health concerns.

However, schools should strive to treat all deaths in the same way. Having one approach for memorializing a student who died of cancer or in a car accident and a different approach for a student who died by suicide reinforces stigma and may be deeply and unfairly painful to the student's family and friends. Refer to the American Foundation for Suicide Prevention's ***After a Suicide: A Toolkit for Schools*** resource, listed in the **Resources** section, for sample notification statements for students and parents or guardians, sample media statements, and other model language.

Finally, it is important for schools to encourage parents and guardians to monitor student social media pages after a death by suicide. Students often turn to social networking websites or apps as outlets for communicating information and expressing their thoughts and feelings about the death. Parents and guardians should be adviced to monitor social media accounts for warning signs of sucicidal behavior. Students should be encouraged to report concerning social media posts, such as tweets, statuses, and Instagram posts.

Best practices regarding safe messaging should be used in all communications about suicide, on social media, and in memorials. This is in order to help reduce the risk of contagion. For school personnel who are concerned that talking about suicide may contribute to contagion, research has shown that talking about mental health and suicide in a nonjudgmental, open way that encourages dialogue and help- seeking does not elevate risk.

Implementation

Implementation

After reviewing this *Model School District Policy*, you may be interested in implementing it in your own school district. If your district has policies and procedures in place, you should examine them to determine if they are comprehensive and address the components outlined in the *Model School District Policy*.

District policies should include the following:

- ☐ Requirement for training – ideally at least one hour every year for all school staff, including bus drivers, cafeteria staff, coaches, security, etc. – on suicide prevention, including education about mental health and warning signs or risk
- ☐ Consideration of populations at high risk for suicide, such as LGBTQ youth
- ☐ Requirement for a designated school suicide prevention coordinator
- ☐ Description of all suicide prevention team member roles and responsibilities, and the flow of communication and tasks
- ☐ Designation of the process for suicide risk assessments (either with school-employed mental health professionals or by arrangement with a community mental health professional)
- ☐ Requirement for continuously-updated referral list that has, at the minimum, emergency contacts such as local hospitals and their mental health clinics and referral numbers
- ☐ Procedures for in-school suicide attempt, including re-entry processes
- ☐ Consideration of out-of-school suicide attempts and how parents should be informed and involved
- ☐ Postvention procedures that follow the ***After a Suicide: A Toolkit for Schools*** recommendations and safely discuss a suicide attempt or death with the school community

If your district policies do not have any of these components, revisions or enhancements are recommended.

Appendix

Resources

Guidebooks and Toolkits

Preventing Suicide: A Toolkit for High Schools

U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration Center for Mental Health Services
store.samhsa.gov/product/Preventing-Suicide-A-Toolkit-for-High-Schools/SMA12-4669

After a Suicide: A Toolkit for Schools

American Foundation for Suicide Prevention and Suicide Prevention Resource Center
afsp.org/schools

Guidelines for School-Based Suicide Prevention Programs

American Association of Suicidology
sprc.org/sites/sprc.org/files/library/aasguide_school.pdf

Youth Suicide Prevention, Intervention, and Postvention Guidelines: A Resource for School Personnel

Maine Youth Suicide Prevention Program
maine.gov/suicide/docs/Guidelines%2010-2009--w%20discl.pdf

Trevor Resource Kit

The Trevor Project
thetrevorproject.org/resourcekit

Supportive Families, Healthy Children: Helping Families with Lesbian, Gay, Bisexual & Transgender (LGBT) Children

Family Acceptance Project
familyproject.sfsu.edu/publications

National Center for School Crisis and Bereavement

schoolcrisiscenter.org/

Supporting the Grieving Child and Family

American Academy of Pediatrics
schoolcrisiscenter.org/wp-content/uploads/2017/04/Final-Clinical-Report-Supporting-the-Grieving-Child-and-Family.pdf

Guidelines For Schools Responding to a Death by Suicide

National Center for School Crisis and Bereavemnet
https://www.schoolcrisiscenter.org/wp-content/uploads/2019/07/guidelines-death-by-suicide.pdf

Adolescent and School Health Resources

Centers for Disease Control and Prevention

An assortment of resources and tools relating to coordinated school health, school connectedness, and health and academics
cdc.gov/healthyyouth/index.htm

Erbacher, T. A., Singer, J. B., & Poland, S. (2015). *Suicide in schools: A practitioner's guide to multi-level prevention, assessment, intervention, and postvention*. New York: Routledge. Chapter 5 provides a model state-wide suicide prevention program.

Poland, S., & Poland, D. S. (2017). Montana's CAST-S: *Crisis Action School Toolkit on Suicide*. Charleston: CreateSpace.
https://saom.memberclicks.net/assets/SAM_unpublished_links/CAST-S%202017%20FINAL_revised.pdf

California Department of Education Model School Policy for Suicide Prevention

cde.ca.gov/ls/cg/mh/suicideprevres.asp

School Programs

Signs of Suicide Prevention Program (SOS) – Screening for Mental Health, Inc.

mentalhealthscreening.org/programs/sos-signs-of-suicide/prevention

Lifeguard Workshop Program

The Trevor Project
thetrevorproject.org/adulteducation

More Than Sad: Suicide Prevention Education for Teachers and Other School Personnel

American Foundation for Suicide Prevention
afsp.org/MoreThanSad

Sources of Strength – Spreading Hope, Health and Strength

sourcesofstrength.org

Crisis and Support Services for Students

Crisis Text Line

Text TALK to 741-741 to text with a trained crisis counselor for free, 24/7

National Suicide Prevention Lifeline

The Lifeline is a 24-hour, toll-free suicide prevention service available to anyone in suicidal crisis or their friends and loved ones. Call 1-800-273-TALK (8255). Callers are routed to the closest possible crisis center in their area.
suicidepreventionlifeline.org

Trevor Project

TrevorLifeline

The only nationwide, 24/7 crisis and suicide prevention lifeline offering free and confidential counseling for LGBTQ youth, available at 1-866-488-7386.

TrevorChat

A free, confidential and secure instant messaging service that provides live help for LGBTQ youth by trained volunteers 24/7.
TheTrevorProject.org/Help

TrevorText

Text "TREVOR" to 678-678. Standard text messaging rates apply. Available 24/7.

TrevorSpace

An online international peer-to-peer community for LGBTQ young people and their friends
thetrevorproject.org

Relevant Research

Youth Risk Behavior Surveillance System

Centers for Disease Control and Prevention. Monitors health-risk behaviors among youth, including a national school-based survey conducted by CDC and state, territorial, tribal, and local surveys conducted by state, territorial, and local education and health agencies and tribal governments.
cdc.gov/healthyyouth/yrbs/index.htm

2012 National Strategy for Suicide Prevention

A report by the U.S. Surgeon General and the National Alliance for Suicide Prevention outlining a national strategy to guide suicide prevention actions. Includes up-to-date research on suicide prevention.
surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf

Working with the Media

Recommendations for Reporting on Suicide

American Foundation for Suicide Prevention, et al.
reportingonsuicide.org

LGBTQ+ and Suicide Risk: Talking about Suicide and LGBT Populations

American Foundation for Suicide Prevention
afsp.org/lgbtq

The National Association for School Psychologists

Guidelines for responsible media coverage of crisis events impacting children and youth.
nasponline.org/about-school-psychology/media-room/press-releases/responsible-media-coverage-of-crisis-events-impacting-children-and-youth

End Notes

1. Centers for Disease Control and Prevention. (2017). Web-based Injury Statistics Query and Reporting System [Data file]. Retrieved from webappa.cdc.gov/sasweb/ncipc/mortrate.html.
2. Centers for Disease Control and Prevention. (2016). Web-based Injury Statistics Query and Reporting System [Data file]. Retrieved from webappa.cdc.gov/sasweb/ncipc/mortrate.html.
3. Centers for Disease Control and Prevention. (2015). Suicide Facts at a Glance. Retrieved from https://www.cdc.gov/violenceprevention/pdf/suicide-datasheet-a.pdf.
4. U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. (2012). *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action*. Washington, DC: HHS.
5. *Lethal Means Counseling: A Role for Colorado Emergency Departments to Reduce Youth Suicide*. (2017). [Online Course]. Retrieved from https://www.train.org/colorado/welcome.
6. Katz-Wise, S., Rosario, M., & Tsappis, M. (2016). LGBT Youth and Family Acceptance. *Pediatr Clin North Am.,63*(6), 1011-1025. doi:10.1016/j.pcl.2016.07.005
7. National Association of School Psychologists (NASP). (2017). *Safe and supportive schools for LGBTQ+ youth (Position statement)*. Bethesda, MD: NASP.
8. Cha, C., Franz, P., Guzman, E., Glenn, C., Kleiman, E., Nock, M. (2018). Annual Research Review: Suicide among youth - epidemiology, (potential) etiology, and treatment. *Journal of Child Psychology and Psychiatry, 59*(4), 460-482. doi: 10.111/jcpp.12831
9. Merikangas, K. R., He, J., Burstein, M., Swanson, S. A., Avenevoli, S., Cui, L., … Swendsen, J. (2010). Lifetime prevalence of mental disorders in US adolescents: Results from the National Comorbidity Survey Replication-Adolescent Supplement (NCS-A). *Journal of the American Academy of Child & Adolescent Psychiatry, 49*(10), 980–989. doi:10.1016/j.jaac.2010.05.017
10. Stockburger, S. (2017). Nonsuicidal self-injury related to suicide. *International Journal of Child Health & Human Development, 10*(4), 383–390.
11. Parra-Uribe, I., Blasco-Fontecilla, H., Garcia-Parés, G., Martínez-Naval, L., Valero-Coppin, O., Cebrià-Meca, A., … Palao-Vidal, D. (2017). Risk of re-attempts and suicide death after a suicide attempt: A survival analysis. *BMC Psychiatry, 17*(1), 163. doi:10.1186/s12888-017-1317-z
12. Scott, M., Underwood, M., & Lamis, D. (2015). Suicide and Related-Behavior Among Youth Involved in the Juvenile Justice System. *Child & Adolescent Social Work Journal, 32*(6), 517–527. doi: 10.1007/s10560-015-0390-8
13. Okpych, N. J., & Courtney, M. E. (2018). Characteristics of Foster Care History as Risk Factors for Psychiatric Disorders Among Youth in Care. *American Journal of Orthopsychiatry, 88*(3), 269–281. doi:10.1037/ort0000259
14. Barnes, A. J., Gilbertson, J., & Chatterjee, D. (2018). Emotional Health Among Youth Experiencing Family Homelessness. *Pediatrics,141*(4). doi:10.1542/peds.2017-1767
15. Fulginiti, A., Rice, E., Hsu, H.-T., Rhoades, H., & Winetrobe, H. (2016). Risky integration: A social network analysis of network position, exposure, and suicidal ideation among homeless youth. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 37*(3), 184–193. doi:10.1027/0227-5910/a000374

16. Centers for Disease Control and Prevention. (2017). Web-based Injury Statistics Query and Reporting System [Data file]. Retrieved from webappa.cdc.gov/sasweb/ncipc/mortrate.html.

17. Kann, L., O'Malley OLsen, E., McManus, T., Harris, W., Shanklin, S., Flint, K., … Zaza, S. (2016). Sexual Identity, Sex of Sexual Contacts, and Health-Related Behaviors Among Students in Grades 9-12 - United States and Selected Sites, 2015. *Morbidity and Mortality Weekly Report, 65*(SS09), 20-21.

18. James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The Report of the 2015 U.S. Transgender Survey*. Washington, DC: National Center for Transgender Equality.

19. Young, I., Igelwicz, A., Glorioso, D., Lanouette, N., Seay, K., Ilapakurti, M., Zisook, S. (2012). Suicide Bereavement and Complicated Grief. *Dialogues in Clinical Neuroscience, 14*(2), 5.

20. Giannini, M. J., Bergmark, B., Kreshover, S., Elias, E., Plummer, C., O'Keefe, E. (2010). Understanding suicide and disability through three major disabling conditions: Intellectual disability, spinal cord injury, and multiple sclerosis. *Disability and Health Journal, 3*(2), 74-78.

21. Suicide Prevention Resource Center (SPRC). (2014). *Suicide and Bullying (Issue Brief)*. Newton, MA: SPRC.

22. Centers for Disease Control and Prevention (CDC), National Center for Injury Prevention and Control, Division of Violence Prevention. (2014). *The Relationship Between Bullying and Suicide: What We Know and What it Means for Schools*. Chamblee, GA: CDC.

23. Alavi, N., Reshetukha, T., Prost, E., Antoniak, K., Patel, C., Sajid, S., & Groll, D. (2017). Relationship between Bullying and Suicidal Behaviour in Youth presenting to the Emergency Department. *Journal Of The Canadian Academy Of Child And Adolescent Psychiatry, 26*(2), 70–77.

24. Kosciw, J. G., Greytak, E. A., Giga, N. M., Villenas, C. & Danischewski, D. J. (2016). *The 2015 National School Climate Survey: The experiences of lesbian, gay, bisexual, transgender, and queer youth in our nation's schools*. New York: GLSEN.

25. Erbacher, T. A., Singer, J. B., & Poland, S. (2015). School Liability and Implications for Best Practice. *Suicide in schools: A practitioners guide to multi-level prevention, assessment, intervention, and postvention* (pp. 50-72). New York: Routledge, Taylor & Francis Group.

26. Hanson, K., & Garcia, A. (n.d.). Mental Health Professionals' Duty to Warn. Retrieved from http://www.ncsl.org/research/health/mental-health-professionals-duty-to-warn.aspx

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